State of Tennessee
Department of Health
Health Related Boards

Reflexology Registry

Heritage Place Metro Center
227 French Landing, Suite 300
Nashville, TN 27243

(Toll Free In State) 1-800-778-4123
Local Nashville Area 615-532-3202
www.tennessee.gov

Application and Procedures for Registration

As a Reflexologist

PH#3712
Rev.06/06

RDA S 836-1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
Reflexology Registry
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

Reflexology Registry

(615) 532-3202 or 1-800-778-4123

LICENSURE APPLICATION INSTRUCTIONS AND CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for registration as a reflexologist in Tennessee. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Registry.**

ALL APPLICANTS MUST COMPLETE ITEMS 1-4	**DONE**
1. Complete, sign, have notarized and mail the application pages 1 through 6.	_____
2. Attach to the application in the space provided a clear , recognizable, recently taken, "passport-style" photograph which shows the full head, face forward from at least the top of the shoulders up of yourself.	_____
3. Submit with your application a check or money order in the amount of $110.00 made payable to the State of Tennessee.	_____
4. If the applicant has ever been authorized to practice as a reflexologist or any other health profession in any state or country, the applicant shall cause to be submitted the equivalent of a Tennessee Certificate of Endorsement from such licensing agency. (Attachment 2)	_____
5. A criminal background check is required. For instructions to obtain a criminal background check, click here or go to the Noteworthy section of the Registry's website	_____

PH 3712
Rev (08/06)

RDA/S 836-1

Read the following qualifications for licensure to apply.

EDUCATION:

1. An applicant shall cause to have submitted documentation of completion of a two hundred (200) hour reflexology only course. It is the applicant's responsibility to request that such documentation be submitted directly from the appropriate agency.

2. An applicant shall submit proof that he/she has attained eighteen (18) years of age.

3. An applicant shall provide evidence of good moral character by submitting two (2) original letters attesting to the applicant's character from health care professionals on the signator's letterhead. The letters cannot be from the immediate family and/or relatives.

4. A passport- style photograph.

5. An applicant shall cause to have submitted documentation of their criminal background check directly from the appropriate agency.

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs <u>at any time, you must</u> notify the Board office, in writing, immediately.

1. All application fees are non-refundable.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

State of Tennessee
Department of Health
Health Related Boards
Reflexology Registry
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

For Federal Express or Special Courier:
State of Tennessee
Department of Health
Health Related Boards
Reflexology Registry
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services <u>will not</u> appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you <u>will</u> be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

4. **We will discuss application status with the applicant, applicant's spouse, or to whom ever may hold power of attorney <u>only</u>.** Please inform hospitals, employers, recruiters, referral companies, or insurance companies that application status updates must be obtained from the applicant. Status information will be mailed to the address listed on the application.

5. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by mail.

6. **Absent any complicating factors, <u>the average application processing time is six (6) weeks.</u> Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination.**

7. It is recommended that you <u>do not</u> make arrangements to accept employment as a Speech Pathologist/Audiologist Practitioner in Tennessee unless you are ASHA certified or until you are granted a license by the Board of Communication Disorders and Sciences.

8. Applications that are deficient sixty (60) days after receipt of the initial deficiency letter will be closed.

ATTACH A CURRENT FULL-FACED PHOTOGRAPH

Reflexologist
A. 4082 - 001 - $100
4082 - 006 - $ 10
$110

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

Reflexology
(615)532-5132
Registration as a Reflexologist

Applicant: Read all instructions carefully and complete all portions applicable to you.
Please type or print
In ink. If a question does not apply to you place a **N/A** in the appropriate space.
_____ Education

All APPLICATION FEES ARE NON-REFUNDABLE
ATTACH CHECK OR MONEY ORDER HERE IN THE AMOUNT OF $110.00 FOR ***REFLEXOLOGIST****.*
MAKE CHECK PAYABLE TO: STATE OF TENNESSEE

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden

Social Security Number: ___-___-___ Date of Birth:_____

Mailing Address:_____ County (TN Applicants Only): _____
_____
_____ Phone: Home: (____) ____-____
_____ Office: (____) ____-____

Email Address: _____

Place of Birth: _____ Sex: (optional - for statistical purposes only)
Female _____
U.S. Citizen: Yes _____ No _____ Male _____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond junior high or middle school. Use the back of this page if you need additional space.

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

Practicum (300 clock hours of supervised, direct clinical practice). Give dates and brief description.
_____
_____
_____

EMPLOYMENT STATUS
Are you currently employed? [ ] Yes [ ] No If yes, give name and address of primary

DATES **LOCATION** **POSITION AND DUTIES**

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr (City) (State) _____

_____

LICENSURE AND CERTIFICATION INFORMATION

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED PERMITTED OR CERTIFIED** as a Reflexologist. Additional pages may be added if necessary. Submit a copy of Licensure verification form to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATED ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a Speech Pathologist/Audiologist. Submit a copy of Licensure verification form to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATED ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ORGANIZATION/ASSOCIATION	LOCATION	DATE OF MEMBERSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

	Yes	No
1. Are you certified by the ARBC (American Reflexology Certification Board) or IIR (International Institute of Reflexology)?	_____	_____
2. Are you certified by any national or international recognized Reflexology organization other than the ARCB pr IIR?	_____	_____
3. Have you ever previously applied for registration as a Reflexologist in Tennessee?	_____	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative,** attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, to learn, and keep abreast of developments in your profession;

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devises, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

	YES	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?		
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	_____	_____
[If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed, or whether you are not eligible for licensure or certification.]	_____	_____

COMPETENCY INFORMATION CONTINUED	Yes	No
QUESTIONS:	____	____
2. Do you currently use chemical substances?	____	____
a. If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____
3. Are you currently engaged in the illegal use of controlled substances?		
a. If yes, are your currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	____ ____	____ ____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?		
5. If you have ever held or applied for a license or certificate to practice Speech Pathology/Audiology in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	____ ____	____ ____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined, voluntarily surrendered under threat or restriction, or disciplinary action?	____ ____	____ ____
7. Have you ever failed a Speech Pathology/Audiology licensure examination?	____	____
8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	____ ____	____ ____
9. Have you ever been rejected or censured by a professional society?	____	____
10. In relation to the performance of your professional services in any profession:	____	____
a. Have you ever had a final judgment rendered <u>against</u> you;	____	____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or		
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	____	____
11. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?		

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn and
(Applicant's Name) (City) (State)
identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, which were enclosed in the application packet, and agree to abide by the them in the practice of Reflexology in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Registrar may find necessary, which may include a full Registrar interview.

RELEASE to the Registrar, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice Reflexology.

AUTHORIZE the Registrar, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Registrar, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

In order to comply with federal statutes, the (Reflexology Registry) is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, 20

_____
NOTARY PUBLIC Affix Seal Here

My Commission Expires _____

ATTACHMENT I

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

Reflexology Registrar
(615) 532-3202 or 1-(800)-778-4123
EDUCATION VERIFICATION

APPLICANT: Supply the information requested in the box below, and then mail this entire form to the educational institution(s) where you completed your two hundred (200) hour reflexology only course. **NOTE:** Most educational institution(s) require a fee, so you may wish to contact the institution before mailing this form. If you attended more than one educational institution, please send copies of this form to each one you intend to rely upon in obtaining licensure.

TO WHOM IT MAY CONCERN:

I am applying for a certificate or permit to Reflexology in the State of Tennessee. The Reflexology Registrar requires verification of educational attainment. Please forward an original transcript showing degree awarded and bearing the institution's official seal to the Registrar's address below.

Applicant's Full Name _____
(Last) (First) (Middle/Maiden)

Applicant's Address:_____
_____
_____
_____

Applicant's Social Security Number: _____-_____-_____

Applicant's Student Identified Number:_____

Date of Graduation: _____

Please forward an original graduate transcript bearing the institution's official seal to:

Reflexology Registrar
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

ATTACHMENT # 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

Reflexology Registrar
(615) 532-3202 or 1-(800)-778-4123
CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the certification board in EACH state where you **hold or have ever held** a certificate/license/permit to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish the contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a (**circle one)** license/certificate/permit to practice _____
(Profession)
with (**check one**) License □/Certificate □/Permit □ number _____ on _____
(Date)
in the State of _____. The Tennessee Reflexology Registrar requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Reflexology Registrar.

Date:_____

_____
Applicant's Signature

_____
Applicant typed or printed name

Name In Full As It Appears On License/Certificate or Permit:
_____
(First) (M.I.) (Last)
License/Certificate/Registry Number: _____ Profession: _____

Date Issued:_____Date of Expiration: _____

Basis of issuance: _____Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____
(Name of Exam)
_____ Other _____
The License is currently active and registered? _____Yes _____ No
Is there any derogatory information on file?___ Yes ____ No If yes, Please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

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